Indiana State Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101244	AND I EAR OF CONNECTION IDENTIFICATION NOWIDEN.		A. BUILDING:			
		004975	B. WING		C 11/08/2010	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SAINT CA	THERINE REGIONAL HO	SPITAL 2200 MAR	KET ST TOWN, IN 471	11		
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	d (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
S 000	INITIAL COMMENTS		S 000			
	This visit was for the i complaints.	investigation of two (2) State				
		654 ck of sufficient evidence; d to the allegations are cited.				
Complaint # IN00078873 Substantiated: Deficiencies related to the allegations are cited. Facility #: 004975						
	Date: 11-8-10 Surveyor: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor QA: claughlin 01/06/11					
S 418	410 IAC 15-1.4-2 QUIMPROVEMENT	ALITY ASSESSMENT AND	S 418			
	410 IAC 15-1.4-2(b)(1	1)(2)				
	(b) The hospital shall appropriate action to a opportunities for improthrough the quality as improvement program	address the ovement found sessment and				
	(1) The action shall be	e documented.				
	(2) The outcome of the documented as to its continued follow-up a patient care.	effectiveness,				

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 09/10/2014 FORM APPROVED

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		A. BOILDING					
	00.4075	B WING		C			
	004975	B. WIIVO		11/08/2010			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SAINT CATHEDINE DECIONAL HOSDITAL							
CHARLESTOWN, IN 47111							
SUMMARY STATEMENT OF DEFICIENCIES (FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL G REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SH	OULD BE COMPLETE			
Continued From page	: 1	S 418					
Based on document of facility failed to ensure address opportunities patient (#PF1, #PF4) Findings include: 1. Review of Policy ti 11-8-10, most recently 10/10, indicated the for event is an event whice	eview and interview, the e appropriate action to for improvement for 2 of 4 records reviewed. Itled Event Reporting on y reviewed by the facility ollowing: Definition: Anoth is out of the ordinary and						
visitor, or employee; of damage to hospital or includes unanticipated and medication errors following: In no case filed with the medical an event must begin we Procedure, point 8 inc.	poccupational illness; or patient property. This also doutcomes/adverse events are. Under Policy indicates the should the event report be record. Investigation into within 24 hours of the event.						
meeting with reporting Board for review and 2. Review of patient in occurrence reports or concern/complaints with bruises on 2 patients of the facility complair were treated as compinvestigated or follower communication as conrequired per facility por 2. Review of the facil Performance Improveminutes from July - O	g to MEC and Governing recommendations. needical records and in 11-8-10 indicated where voiced regarding (#PF1 and #PF4). Review into log lacked evidence these plaints/grievances, ed-up with written implaints/grievances as policy. ity Quality Assurance and imment (QAPI) meeting ctober 2010 lacked						
	THERINE REGIONAL HO SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page This RULE is not me Based on document r facility failed to ensure address opportunities patient (#PF1, #PF4) Findings include: 1. Review of Policy ti 11-8-10, most recently 10/10, indicated the fe event is an event which has a potential for or a visitor, or employee; of damage to hospital or includes unanticipated and medication errors following: In no case filed with the medical an event must begin to Procedure, point 8 includes and with the medical an event must begin to Procedure, point 8 includes and for review and 2. Review of patient no occurrence reports or concern/complaints we bruises on 2 patients of the facility complair were treated as comp investigated or followed communication as con required per facility po 2. Review of the facil Performance Improve minutes from July - O evidence that these of	THERINE REGIONAL HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure appropriate action to address opportunities for improvement for 2 of 4 patient (#PF1, #PF4) records reviewed.	THERINE REGIONAL HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure appropriate action to address opportunities for improvement for 2 of 4 patient (#PF1, #PF4) records reviewed. Findings include: 1. Review of Policy titled Event Reporting on 11-8-10, most recently reviewed by the facility 10/10, indicated the following: Definition: An event is an event which is out of the ordinary and has a potential for or actual injury to a patient, visitor, or employee; occupational illness; or damage to hospital or patient property. This also includes unanticipated outcomes/adverse events and medication errors. Under Policy indicates the following: In no case should the event report be filed with the medical record. Investigation into an event must begin within 24 hours of the event. Procedure, point 8 indicates: Event reports will be reviewed monthly at the Quality Council meeting with reporting to MEC and Governing Board for review and recommendations. 2. Review of patient medical records and occurrence reports on 11-8-10 indicated concern/complaints were voiced regarding bruises on 2 patients (#PF1 and #PF4). Review of the facility complaint log lacked evidence these were treated as complaints/grievances, investigated or followed-up with written communication as complaints/grievances as required per facility policy. 2. Review of the facility Quality Assurance and Performance Improvement (QAPI) meeting minutes from July - October 2010 lacked evidence that these complaints/grievances were	THERINE REGIONAL HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure appropriate action to address opportunities for improvement for 2 of 4 patient (#PF1, #PF4) records reviewed. Findings include: 1. Review of Policy titled Event Reporting on 11-8-10, most recently reviewed by the facility 101, indicated the following: Definition: An event is an event which is out of the ordinary and has a potential for or actual injury to a patient, visitor, or employee; occupational illness; or damage to hospital or patient property. This also includes unanticipated outcomes/adverse events and medication errors. Under Policy indicates the following: In no case should the event report be filled with the medical record. Investigation into an event must begin within 24 hours of the event. Procedure, point 8 indicates: Event reports will be reviewed monthly at the Quality Council meeting with reporting to MEC and Governing Board for review and recommendations. 2. Review of patient medical records and occurrence reports on 11-8-10 indicated concern/complaints were voiced regarding bruises on 2 patients (#PF1 and #PF4). Review of the facility complaint log lacked evidence these were treated as complaints/grievances, investigated or followed-up with written communication as complaints/grievances as required per facility policy. 2. Review of the facility Quality Assurance and Performance Improvement (QAPI) meeting minutes from July - October 2010 lacked evidence were			

Indiana State Department of Health

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					C
		004975	B. WING		11/08/2010
NAME OF D	DOVIDED OD SLIDDLIED	QTDEET A	DDDESS CITY STA	TE ZID CODE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST					
SAINT CA	THERINE REGIONAL HO)SPITAL	STOWN, IN 471	11	
	CLIMMA DV CT		·		N
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S 418	Continued From page	2	S 418		
S 744	meetings July - Octobro 3. Interview with #S1 confirmed the concern found on patients #PF investigated, staff was concerns were not discommittee meetings of meetings from July - 04. Interview with #S3 confirmed the compla patients #PF1 and #F staff was not interview discussed at the facilia	oer 2010. on 11-8-10 at 1411 hours ns/complaints of bruising =1 and #PF4 were not s not interviewed and the scussed at the facility QAPI or any other committee October 2010. on 11-8-10 at 1415 hours nints of bruising found on PF4 was not investigated, wed and the issues were not ity QAPI meetings or any tings from July - October	S 744		
	SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be:				
(1) legible and complete;		ete;			
	facility failed to ensure record, including physical	review and interview, the			
	Findings include:				
	indicated #PM1 was	medical records on 11-8-10 discharged to a nursing view of patient medical			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		5 4444		С		
		004975	B. WING		11/08/2010	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SAINT CA	THERINE REGIONAL HO	SPITAL 2200 MAR				
			TOWN, IN 471			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
S 744	Continued From page	2 3	S 744			
	discharged to a nursing patients' medical record of a physician dischargent and #PM3. 2. Interview with #S1 confirmed there was a discharge patient #PM3. Interview with #S1	M1. and #S2 on 11-8-10 at I there was no physician				
S 930 410 IAC 15-1.5-6 NURSING SERVICE		S 930				
	410 IAC 15-1.5-6 (b)(3)				
	(b) The nursing service shall have the following:(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.					
	registered nurse failed the care of patients by	eview and interview, the d to supervise and evaluate y not ensuring facility followed for 1 of 3 (#PF1)				
	Findings include:					
	Hygiene on 11-8-10 ir patient will receive a better than twice weekly. 2. Review of patient indicated patient #PF	nursing policy Personal ndicated the following: Each path and /or shower no less medical records on 11-8-10 1 was admitted to the con 8-5-10 and received				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			23.25.110		С	
		004975	B. WING		11/08/2010	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SAINT CA	THERINE REGIONAL H	OSPITAL	ARKET ST			
	OLIMAN DV OT		STOWN, IN 4711			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
S 930	Continued From page	e 4	S 930			
	did not receive a batt 8-14-10, which is 8 d 3. Interview with #S2 indicated patient #PF Tuesday/Saturday batacility policy requires bath/shower no less indicated patient #PF bath/shower on 8-10-	on 11-8-10 at 1615 hours I should have been on the ath/shower schedule and a patients to have a than twice weekly. #S1				
S1164	410 IAC 15-1.5-8 PH	YSICAL PLANT	S1164			
	410 IAC 15-1.5-8(d)(2)(B)				
	(d) The equipment refollows: (2) There shall be surequipment and space safe, effective, and ti of the available service as follows:	fficient e to assure the mely provision				
	(B) There shall be expreventive maintenar equipment.					
	facility failed to ensur	et as evidenced by: review and interview, the re bed alarms are tested and or to assure patient safety.				
	Findings include:					
	11-8-10 indicated pat	occurrence reports on tient #PF3 was found on the on 9-8-10. The occurrence				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		004975	B. WING		C 11/08/2010		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SAINT CATHERINE REGIONAL HOSPITAL 2200 MARKET ST CHARLESTOWN, IN 47111							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
S1164	report indicated that a 2. Interview with #S3 indicated that bed ala make sure they are in the bed alarms are no alarm when a patient only checked to make #S3 indicated he/she alarm worked at the t and indicated they are	a bed alarm was in place. on 11-8-10 at 1428 hours rms are checked daily to a place. #S3 indicated that bit tested to assure they will leaves the bed; they are a sure they are in place. does not know if the bed ime of patient #PF3's fall	S1164				

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